Implementing Medicare Part D

A Practical Implementation Plan
for Community Behavioral Health
Providers

Presenters

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Topics

- Using a work group for implementation
- Prioritizing your Medicare clients
- Gathering the necessary data
- The prescriber role
- Maintaining productivity—what's billable?
- Assisting consumers with plan selection
- 1/1 and beyond

Focus on applying (not reviewing) the rules

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A Practical Implementation Plan for Part D

Work Group Approach pg 77

- Group composition
  - Prescriber, front desk, financial, MIS, case management
- Implementation manager
  - Employed or contracted
- Sharing resources across providers
  - Implementation mgr and plan research could be shared across agencies

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Work Group Approach

- Train work group
- Determine organization's approach to transition
  - Level of consumer assistance, priority clients, resources for assistance
  - Resources and time frames will limit assistance capacity
- Gather data
  - Organizational, client and plan
  - State wrap around benefits, if any

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Work Group Approach

- Develop/document new procedures
  - Front desk—checking eligibility, updating Medicare drug plan info
  - Medical services—practicing within formulary, assisting with appeals
  - Case mgt/other clinical services—responding to consumer questions, referring issues to group leader

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Work Group Approach

- Develop training and communication tools
  - Train affected staff
  - Create communication devices—reports, shared network drive, etc.
- Feedback loop
  - Plan to evolve processes/information as transition proceeds

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Possible Shared Tools/ Templates

- List of plan websites for enrollment, formulary and appeal procedures
- List of most frequently used medications (top 50 – 100)
- Tailored plan analysis form
- Appeal templates by plan
- Billable activities pg 92

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Prioritizing Most Vulnerable

- Dual Eligibles
- Hospital to Community Transitions
- Newer, brand name drugs
- Multiple previous failures on prior drugs
- Many physical health issues as well as complex psychiatric medication issues

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Gathering Data—Your Own

- Medicare eligible clients
  - Duals
  - Non-Medicare SMI
  - Eligible for LIS—encourage/assist consumer to apply now http://ssa.gov/prescriptionhelp pg 28
- Most frequently prescribed BH meds
  - Data, if available
  - Work with prescribers to develop list
  - Not only BH meds (anti-convulsants)

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Gathering Data—Your Own

- Frequently used pharmacies
  - Check whether key pharmacies are included in plans' networks
  - Availability/access to pharmacy networks varies significantly by plan
    - Online search by zip
    - Not yet available for one plan, per telephone customer service

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Gathering Data—The Plans

- Select 3 – 5 priority PDP/Medicare Advantage plans
  - Eligible for Low Income Subsidy (LIS)
    - List of plans by state at (zz = state abbreviation) www.cms.hhs.gov/map/charts/chart3zz.pdf
  - Premium at/near LIS level
  - Focus on national plans or local with history
    - Less disruption in year 2
  - Look at other plans if priority plans don't meet a particular consumer's needs.

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Gathering Data—The Plans

- For each plan
  - Formulary
    - Appears to be one formulary per company with varying copay levels by plan
    - Appears not to be variable by dosage
  - Prior authorization
  - Pharmacy network
  - Enrollment process
  - Appeals process

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Gathering Data—The Plans

- Develop “cheat sheet”
  - Most frequently used meds in rows down the side
  - Copays/prior authorization requirements for priority plans in columns across the top
    - Copays for other than LIS
- Analysis may contribute to general analysis of optimal plans

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Most Frequently Used Drugs Copays/Prior Authorization

	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Ambien	10/N	10/N	10/Y	5/N	5/Y
Risperdol	25/S	35/S	15/Y	25/Y	20/Y
Seroquel	25/Y	35/N	15/N	25/Y	20/Y
Zoloft	10/N	10/N	10/Y	5/N	5/N

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Gathering Data—Your Clients

- Current medications
  - BH and physical health
  - For priority consumers, bring in all medications at next appointment
- Current pharmacy
- Have refillable prescription in place 12/31/05
  - CMS "requiring" plans to honor refills

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Organizational Roles for Prescribers/Clinical Managers

- Leadership
  - Need to be out front to keep agency calm and focused.
  - Need to take lead role in determining priorities, understanding potential problems
  - Need to be ready to deal with managed pharmacy plan managers, medical directors, case managers.

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Organizational Roles for Prescribers/Clinical Managers

- Outreach priorities: which clients first
  - Dual Eligibles
  - Hospital to Community Transitions
  - Newer, brand name drugs
  - Multiple previous failures on prior drugs
  - Many physical health issues as well as complex psychiatric medication issues

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Organizational Roles for Prescribers/Clinical Managers

- Retooling schedules: making sure certain visits happen before Jan 1, 2006
  - Make room for high priority clients as identified.
  - Make room for clients with conflicts between physical health and psychiatric medications as determined by a plan analysis
  - Make room for clients who are asking to move to lower tier medications because of co-pays or other benefit management issues

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Organizational Roles for Prescribers/Clinical Managers

- Refillable prescriptions in place by 12/31/05
  - BH and physical health, as possible
- Tx Plan changes: more med education; more attention by community support
  - Have an agency plan for this
  - Make sure prescribers understand process and additional support being provided.
    - Give them a menu to choose from as they see clients.

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Organizational Roles for Prescribers/Clinical Managers

- Educate other staff: you know medications – they don't.
  - This cannot be delegated to the case management, community support, and therapy staff and just forgotten
  - Active, supportive consultation will be required.
  - Email or other process for asking questions may be critical

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Issues for Prescribers/Clinical Managers

- Transition Plan/After-implementation Plan
  - Make sure the prescriber understands their role

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Issues for Prescribers/Clinical Managers

- Coordination
  - Behavioral inpatient (Part A)
  - Primary/Physical Care

Who will do what?
Who breaks ties?
How will they communicate? Directly or through who?

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Issues for Prescribers/Clinical Managers

- Agency Approach to Continuity of Care: establish relationships now
  - Determine role of prescriber

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Assisting Consumers With Plan Selection pg 87

1. Identify targeted plans, including the plan the consumer has been assigned to in order to start (LIS eligible, national/experienced local, etc.)
2. You will need all gathered data
   - Organization: List (prioritized) of consumers, most frequently used meds
   - Client: all meds consumer is taking including dosage and form of dosage.
   - Targeted plans: formularies, pharmacy network, prior authorization requirements
3. Ask consumer to selected Medicare Advantage Plan or stand alone drug plan
   - May follow historical preferences for original Medicare or HMO
4. Check each of these medications, dosages and forms against the formulary
   - Record if the drug is available, the cost of the co-pay, any benefit management activities it is subject to and what they are

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Assisting Consumers With Plan Selection pg 87

5. Compare medication availability:
   - If any one plan does not have all drugs then do not consider it further.
   - If all plans do not have one or more of the drugs – choose three more plans, if available.
     - If additional plans not available then continue with analysis – note problem medication and seek advise from agency prescriber.
6. When you have identified at least one low cost plan that has all the drugs, add up the co-pays.
   - If one or more drugs is on high co-pay tier note this for potential appeal or coverage decision.

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Assisting Consumers With Plan Selection pg 87

7. Look at benefit management issues--which drugs subject to limits on scripts, prior approvals, etc.
   - Always note the type of benefit management activity, e.g. prior approvals may be as onerous as script limitations or dosage problems.
8. If there is more than one plan that meets availability, criteria compare the two based on co-pay costs and the benefit management activities
   - In some cases lowest cost plan (co-pays) may not be best for client

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Assisting Consumers With Plan Selection pg 87

9. If the first three do not work – go to the next three
   - Medicare software products
     - Not fully tested or complete
     - Difficult for many clients to use.
     - Do not compare co-pays or other benefit management issues – focused primarily on availability.
10 Assist client with enrollment in selected plan
   - Or, change plans if dual eligible with auto-enrollment

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Assisting Consumers With Plan Selection—CMS Resources

- Prescription Drug Plan Finder
  - http://medicare.gov/MPDPF/
  - Designed to find plans for specific consumer
  - Problems:
    - Medicare card needed for Part A/Part B effective date
    - Early problems with website volume
    - Medication analysis function not available as of 10/21
    - Tested for an AZ Medicare beneficiary--78 PDPs were available

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Assisting Consumers with Plan Selection—CMS Resources

- Formulary Finder
  - http://plancompare.medicare.gov/formularyfinder/drugselect.asp
  - Allows entry of specific medications and list all plans that cover that medication
  - Number of available plans undermines usability of this tool

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Example of State Coordination of Benefits—Arizona

- State funds cannot be used if federal benefit available
  - Consumers cannot disenroll and get Medicaid pharmacy benefits
    - Exception for lack of documentation or impact of mental status
- Covering excluded drugs
- Copays for duals
- For Medicare SMI consumers, state will permit RBHAs to pay premiums/copays/coverage gap
  - State has been covering pharmacy benefits for these consumers
  - Financial beneficial, but logistically complex

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1/1 and Beyond

- Appeals and Grievances
  - Appeals require prescriber role –sometimes significant
    - Significant time savings if have routine, forms, time controls, etc. in place
  - Grievances – need to assist clients

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1/1 and Beyond

- Formulary Review
  - They will change during year.
  - Year end significant changes may happen.
  - One year only on coverage of most psych meds.
  - Clients must be able to be seen by medical team that has access to all formulary information in making prescribing decisions.

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1/1 and Beyond

- Drug Plan Changes: benefit management
  - This will likely change during year.
  - Continuous issue for clients
  - Benefit management process must be integrated into treatment
    - E.g. Prior authorizations

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1/1 and Beyond

- Samples and patient assistance management
  - Look for changes as drug companies cut back
  - Will they continue to support Medicare clients who choose not to enroll in Part D? Will you?

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1/1 and Beyond

- Medication Education & Management
  - This will be a continuous process as drugs are added to and taken off the formulary
- Practice Patterns
  - Benefit management is there as a means of changing practice patterns – listen to what they are saying.

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For a preview of "Medicare Part D: Operational Implementation Guide for Community Behavioral Healthcare" or to purchase a copy, please go to BHCollaborativeSolutions.com or nccbh.org
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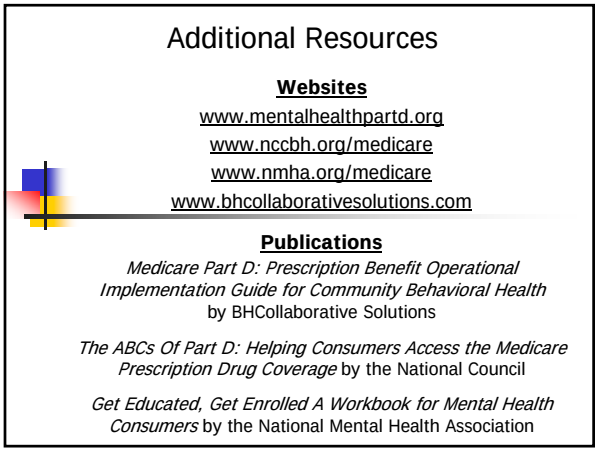
Additional Resources
Websites
www.mentalhealthpartd.org
www.nccbh.org/medicare
www.nmha.org/medicare
www.bhcollaborativesolutions.com
Publications
Medicare Part D: Prescription Benefit Operational Implementation Guide for Community Behavioral Health by BHCollaborative Solutions
The ABCs Of Part D: Helping Consumers Access the Medicare Prescription Drug Coverage by the National Council
Get Educated, Get Enrolled A Workbook for Mental Health Consumers by the National Mental Health Association